Idaho Medicaid Draft Payer Strategy Summary – June 2015

Idaho Medicaid plans to implement changes to its payment structure for its Healthy Connections primary care program to incentivize patient centered medical home development in coordination with the State Healthcare Innovation Plan. Patients are attributed to practices based on their provider selection, or if no provider is selected, based on their past claims and proximity to provider locations and provider availability.

- Providers will receive capitated per member per month payments (PMPM) for attributed patients to support activities directed towards improved patient care and better coordinated services.
- PMPM Payment amounts will vary depending on member and provider characteristics, as outlined in the table below.
- New regulations are under development to support these changes. Providers will have the opportunity to participate in drafting these rules and providing input on specific requirements through negotiated rulemaking sessions scheduled for Summer 2015.

Patient Complexity Payments – Available to All Participating Healthy Connections Primary Care Providers			
Tier	**PMPM amount**	**Qualification for Payment**	**Administrative Requirements**
1a - Basic Plan Participants • *Well children* • *Well adults* • *Pregnant women*	Limited PMPM to reflect the minimal care coordination needs of well patients	**Similar to existing Healthy Connections requirements:** • Provide and coordinate referrals designated services • Management and documentation of patients medications • 24/7 after hours access to a medical professional for purposes of referral to services	**Reduced** • Referral no longer required for services that require physician order

Patient Complexity Payments – Available to All Participating Healthy Connections Primary Care Providers			
Tier	**PMPM amount**	**Qualification for Payment**	**Administrative Requirements**
1b - Enhanced plan participants • *Aged 65 and up* • *Disabled and chronically ill adults* • *Children with special health care needs* • *Individuals with severe and persistent mental illness or serious emotional disturbance*	Higher PMPM amount to provide enhanced care & coordination services to patients with significant health care needs	**Similar to existing Healthy Connections requirements:** • Provide and coordinate referrals designated services • Management and documentation of patients medications • 24/7 after hours access to a medical professional for purposes of referral to services	**Reduced** • Referral no longer required for services that require physician order

Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications			
Tier	**PMPM amount**	**Qualification for Phase One Payments**	**Administrative Requirements**

2 - Patient centered medical home development support
 	
For providers with some patient centered medical home capabilities
	Participant complexity payment as above
	
	+
	
	Additional support to fund transition to a patient centered medical home
		Proposed criteria – similar to existing "Health Homes" program requirements:
		
		Required:
		• Complete a readiness review including a well-defined 1 - 3 year plan for PCMH transformation or other activities indicating a high level of performance (as designated by IHC). Plan progress will be monitored by Medicaid primary care staff.
		• Expanded patient access -
		  ○ 46 hours of access for patients, OR
		  ○ Other methods with demonstrated increased access to care (e.g. same day access, telehealth).
		• Dedicated care coordinator staff or equivalent support for care coordination
		• Establish a connection to the Idaho Health Data Exchange (IHDE)and agree to share clinical data with Medicaid through that connection to support clinical quality measurement
		And one of the following:
		• Enhanced care coordination activities – community paramedic, promotora model, home visiting model, or similar enhanced care coordination model with proven results
		• Population health management capabilities - registry reminder system or other proactive patient management approach
		• Behavioral health integration – co-located or highly integrated model of behavioral and physical health care delivery
		• NCQA level 1 recognition
		• Medication therapy management on site or closely coordinated with a pharmacist
			Reduced
			
			• Referral no longer required for services that require physician order
			• May see other Healthy Connections participants without a referral when communication with attributed PCP is accomplished within 3 business days

Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications			
Tier	**PMPM amount**	**Qualification for Phase One Payments**	**Administrative Requirements**
3 - Established Patient Centered Medical Home *Providers with advanced patient centered medical home capabilities*	Participant complexity payment as above **+** Additional support to fund established patient centered medical home activities	• NCQA level 2 or 3 patient centered medical home recognition, OR URAC, JCAHO, or AAAH patient centered medical home recognition • Connection to IHDE and participation in IHDE clinical reporting development efforts • Expanded patient access as for tier 2 • Quality improvement activities directed at increased performance for quality measures	**Reduced** • Referral no longer required for services that require physician order • May see other Healthy Connections participants without a referral when communication with attributed PCP is accomplished within 3 business days

Quality Measure Reporting

Quality measurement tracking and reporting is a key component of Medicaid's strategy to support patient centered medical homes. Data will be exchanged between Medicaid and the provider, and vice versa. This will be a key piece of future payment strategies.

During the first phase of implementation as outlined in the tables above, a claims data dashboard will be reported back to provider locations by Healthy Connections representatives:

- *Diabetes* – Retinal Eye Exam Performed, Blood Sugar Screening, Cholesterol Screening, Kidney Disease Monitoring
- *Asthma* – Appropriate Medications and ED visits
- *Medication Management* – Annual Monitoring for Patients on Persistent Medication, Antidepressant Medication Management
- *Acute Care Hospitalization* – Percent of patients admitted

Quality measure reporting will expand to include clinical data collected through the Idaho Health Data Exchange for SHIP core measures when that functionality becomes available.

Future Development

This payment structure will be adjusted in future phases of the SHIP effort to allow for payments for quality outcomes based on both claims and clinical data. As the quality outcomes reporting infrastructure becomes more robust, PMPM amounts will be tied to health outcomes, and will increase. Fee for service payments will become a smaller share of total reimbursement. A shared savings approach is the goal for a mature program that strongly supports payment for value.